Across the Bridge, LLC.

Counseling for adolescents and adults

INTAKE FORM

Legal Name: _____ **Date of Birth**: _____**Sex**: Male/Female
Gender Identity: _____ Sexual Orientation: _____
Preferred name: _____ Pronouns: He/him, She/her, They/them, other (_____)
***I need to know your legal name and biologically assigned sex when I submit a claim to your insurance company. If you are would like to use an insurance plan for the treatment, please provide them. ***

Legal Guardian's Name: _____ Relationship: _____
Legal Guardian's Name: _____ Relationship: _____

Phone: Home/Cell (_____)_____ __ (May I leave a message/txt? Yes/No)
Alternative #: (_____)_____(May I leave a message/txt? Yes/No)
Email: _____

Address: _____

Does your child attend a school? Yes/No
If yes, which school does he/she/they attend? _____

Emergency Contact: _____ Relationship:_____
Emergency Contact number: _____

Insurance Co._____ **ID#:** _____
Name of Insured:_____ **Insured DOB:** _____

Medications: (Please list all of the medication that you are currently taking.)
_____
_____
_____
_____

The reason for the treatment:
_____
_____
_____
_____

Has your child received therapeutic treatment in the past? (including hospitalization, PH,IOP, and outpatient) Yes/No
If yes, Date: _____ The provider or program: _____
Date: _____ The provider or program: _____
Date: _____ The provider or program: _____

141 Wall St. Princeton, NJ 08540
609.917.4011
www.yukoinzana.com
yinzana@gmail.com

What would you/your child like to accomplish from the treatment:

_____
_____
_____
_____

Referred by _____

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